Principles in a Hospital Consultation Service

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Discussed here are some principles applicable to hospital consultation activities, developed out of the experience of the authors over a period of nine years of work in a large urban area. The material is timely in view of the broad implications of the purposes of, and the need for, consultative programs evolving from the use of tax funds used to purchase hospital care for certain groups.

Although one of the functions of official public health agencies traditionally has been standard setting and standard raising, hospital consultation in its broad sense has played a relatively minor role in general public health programs. Our experience has indicated that there is a need for greater development in this area. A hospital consultation program is a service provided to hospitals to assist them in improving the quality of patient care, in promoting continuity of the care of the patient between the hospital and the patient's home, and in introducing public health measures. It is not solely a review of the management and care of hospital patients or of the available facilities and equipment, but also includes the relationship of the patients' therapy in the hospital to medical aftercare and a consideration of social, community, and home factors.

From the public health point of view consultation to hospitals may assist in the reduction of mortality, in the control and prevention of outbreaks of infection, in the supervision of legal requirements of good patient care, and in the prevention of overhospitalization of those patients for whom hospital care is being purchased thereby curtailing the wastage of tax funds. Medically the caliber of patient care may be raised through hospital consultation by setting standards for patient care and by bringing recommendations and experiences of many hospital surveys to individual institutions or specialty services. Public health agencies offering hospital consultation attempt to consider the patient's medical and health needs, as well as his relationship to his family and to society. By review of all of the medical and ancillary services concerned, the total care of the patient is held paramount, and attempts are made to promote continuity between hospital treatment and follow-up care at home.

A hospital consultation service may be most effectively carried on by a team of experts representing the various disciplines or specialties concerned with the broad aspects of patient care. While surveys may possibly be carried on by a variety of groups that are reasonably representative in a community, it may be questioned whether standard raising can be effected through many community groups. In order for any community group to be effective in standard raising, certain requisites are essential. The group must be completely impartial and objective and should not have a specific protective or vested interest. The community group engaged in hospital consultation should have some prestige from which specific suggestions and recommendations, when made, will carry some weight and have a desired effect or end result. In our experience,

this service can be effectively rendered by a team of experts on the staff of a health department.

Historically, hospital consultation in its narrow sense began because of the need for public health measures to prevent and control communicable diseases. Thus, when an outbreak of certain communicable diseases occurred in a hospital, public health authorities would immediately dispatch an epidemiologist for epidemiologic study, for the institution of certain control measures to limit further dissemination of the disease, and in some instances to prevent reoccurrences. In the maternal and child health fields, this activity has particularly applied to outbreaks of infection in hospital newborn nurseries.

The second major step in hospital consultation occurred with the advent of the Federal Emergency Maternity and Infant Care Program (EMIC) in operation from 1943 to 1949. In this program, which purchased hospital care for mothers and infants, standards for such care were established by some official health agencies and hospital consultation activities were carried on a somewhat broader basis. As an outgrowth of the EMIC program some health departments initiated more extensive programs for mothers and newborn infants, including those infants born prematurely. Experience over a period of years has demonstrated that this type of activity has been of considerable value in the conservation of human lives and in the improvement of patient care.

The third type of activity occurred with the passage of the Federal Hospital Survey and Construction Act in 1947, when federal funds were made available to the states for hospital planning and construction. In most states, laws were enacted and standards established at least for those hospitals which received federal funds. An as outgrowth, many state health departments initiated hospital consultation programs.

Principles of Hospital Consultation

The principles to be presented and discussed are: (1) coordination of agencies; (2) establishment of standards for patient care; (3) consultation by a multidisciplined team; (4) the "consulting team" attitude; (5) development of methods of consultation; (6) promotion of better community planning; and (7) consideration of legal authority and financial assistance.

Coordination of Agencies—While in many areas of the country hospital consultation activities are usually carried on by only one agency, in some regions several organizations are concerned. In New York City, there are four official city agencies, two official state agencies, and one local voluntary agency, in addition to the national accrediting agencies. In the New York City Department of Health alone there are four separate units carrying on some type of activity in the hospital consultation field. If the individual hospital is to survive and benefit from this barrage of consultants, it is obvious that the various agencies and units concerned must be coordinated. Ideally, they should be integrated into one unit of one agency. If there is more than one agency involved, coordination should be a method of action involving a cooperative effort and sharing activities, information, and reports. If it is limited to a mere theory, the effect of the individual consultations and recommendations upon the individual institution may be chaotic.

Establishment of Standards for Patient Care—A hospital consultation program to be truly effective in improving the level of patient care must have a base line guide of standards. Wherever possible, the same set of standards should be used by all of the agencies in any one community concerned with hospital con-

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sultation and concerned with the purchase of hospital care. Unless the same standards are adopted, agencies may make different recommendations on the same subject to an individual institution with the resultant unnecessary confusion, as well as wastage and unwise expenditure of community funds. All the agencies concerned should participate in the development of standards of care. The various specialists and professional groups should play an active role and be well represented by the community experts in the field. To illustrate, in the development of standards of hospital care of children with orthopedic handicaps, representation should be drawn from the fields of orthopedic surgery, pediatrics, physical medicine and rehabilitation, nursing (both hospital and public health), physical, occupational and speech therapy, social work, vocational rehabilitation, education, psychology, psychiatry, and hospital administration. An advisory committee which is truly representative of the experts in the various fields concerned has been found invaluable.

The hospital standards should place major emphasis on (1) the existence or appointment of qualified directors and staffs (both medical and ancillary) of the services concerned, and (2) the policies and procedures of the hospitals with inclusion of specifications for physical plant and equipment (Table 1). Many of the standards developed throughout the country have overemphasized the provision of an adequate physical plant and have underemphasized the provision of adequate and well trained personnel. One of the knotty and unsolved problems in standards for all types of hospital patients is the lack of definite information about nursing needs, especially in two areas, namely, the amount of nursing care required per patient and the desirable proportion of registered professional nurses to auxiliary personnel. The need for authentic information and well planned studies is urgent, whether it applies to the orthopedically handicapped child, the premature infant, or to the poliomyelitis patient requiring care in a respirator.

Table 1—Contents of Standards * Recommended for the Hospital Care of Children with Orthopedic Handicaps [1]

1. Definition
2. Medical Staff and Policies
3. Nursing Staff
4. Department of Physical Medicine
5. Nutrition Department
6. Laboratory Department
7. X-ray Department
8. Anesthesia Department
9. Social Service
10. Educational Program
11. Service for Psychological Testing
12. Physical Plant
13. Policies and Procedures
14. Records
15. Visiting Hours
16. Arrangement with Community Public Health Nursing Agencies
17. Convalescent Care
18. Referral for Vocational Counseling
19. Employee Health Policies
20. Outpatient Department

* This set of standards recommended for the hospital care of children with orthopedic handicaps has been developed by the Bureau for Handicapped Children of the New York City Department of Health with the assistance of its Orthopedic Advisory Committee. These standards are circulated to all hospitals participating in the medical rehabilitation payment program for the care of orthopedically handicapped children, or those requesting participation. They are used as a basic guide to the hospital, to the consulting team, and the advisory committee in the consideration of approval or disapproval of a hospital in the program.

The fact that a set of standards has been developed should not be accepted as the complete and final answer. As clinical practice changes, and as the hospital consultants and hospital staffs acquire further knowledge and understanding, periodic revision of established standards is indicated. Too often, the established standards belong to a vintage and era which have become outdated and outmoded.

Consultation by a Multidiscipline Team—Consultation in its broad aspects can be maximally effective only if it is conducted by a team of technical specialists in all of the fields concerned. Thus, in a consultation program designed to improve the level of hospital care for children with orthopedic handicaps, the core of the team should include an orthopedic surgeon, a specialist in physical medicine and rehabilitation, a pediatrician, a nurse, and a social worker, with ancillary consultants being readily available for specialized assistance when needed—for example, nutrition, physical therapy, etc. The use of the team method serves several necessary functions: (1) the professional members of the team are all present to evaluate patient care from the viewpoint of their own specialized training and technical skills; (2) the team members may more easily and readily learn from each other and so broaden and improve their own understanding of total patient care; (3) at the time of the conference with the hospital staff after the survey, there is better interpretation by the consulting team members to the hospital staff of the recommendations made particularly in the various specialized and technical areas; and (4) the team members working together serve as an illustration to the hospital staff members of the different departments as to how they may themselves work together on common problems. This last point is best illustrated by an example from our consultation experience in the maternity and newborn field. In the early days of that program there was rivalry and competition as to medical responsibility for the care of the newborn baby, who in fact became "nobody's baby." Because the consulting obstetrician and pediatrician demonstrated their respective areas of responsibility at the surveys and subsequent hospital conferences, the hospital staffs were also better able to define their responsibilities in respect to the newborn nursery services. Their assignment of the newborn service to the pediatric staff then evolved quite amicably.

The "Consulting Team" Attitude—Basically the attitudes of the members of the consulting team set the tone for the hospital consultation program and probably represent one of the most important factors determining the success or failure of the program. If the consulting team members are helpful, fair, courteous, practical, and cooperative, and if they are technically skilled in their respective specialties, there is usually good rapport with the hospital staff. On the first contact the consulting team must convince the hospital staff that the purpose of the survey is to assist them in improving their services and the care of the patients. To many hospitals and hospital staff members hospital consultation from a public health agency is something new and something to be feared. The methods and purposes must be carefully explained so that the staff will recognize that the recommendations made following the survey are not in the sense of criticism of the services, but are suggestions based on a large number of surveys of similar institutions, as well as on accepted standards of good patient care.

It is essential that the hospital staff members feel that the consulting team is anxious and ready to assist them in every way possible in solving their problems and in fulfilling the recommendations that are made. For example, a survey was made in a 50-bed children's orthopedic service in a 2,200-bed general hospital. There was no closely knit service for the children with orthopedic handicaps in that these beds were scattered in four separate floors and wings, among pediatrics, dermatology, general surgery, chest surgery, and neurology. The difficulty of the attending orthopedic staff in making daily ward rounds and in giving daily supervision was obvious. The director of the ortho-

pedic surgical service was asked by one of the members of the consulting team if it might not be easier for him and his staff if there were a definite section of the hospital allocated to the children's orthopedic service. His quick reply was that he had been trying to accomplish this for several years without success. He was asked whether it would help if we made such a recommendation with suggestions as to how it might be accomplished. When he recognized that our purpose was to assist him in improving his service and not to criticize, the survey proceeded very smoothly and effectively with the maximum cooperation of the hospital staff.

Development of Methods of Consultation—Essentially a hospital consultation program has several specific components: (1) the survey; (2) the preparation and sending of a letter of recommendations; (3) the postsurvey conference at the hospital; and (4) follow-up activities depending on the individual need.

The survey is made on an appointment basis only, and usually from two to four weeks elapse between the time the appointment is made and the date of the survey. This is an essential principle in the preservation of a good working relationship with the institution and there is no reason or need to take the institution by surprise. An experienced hospital consultant will be able to observe innumerable areas requiring improvement in patient care even in the "best prepared" hospital. The hospital should be informed as to the personnel of the consulting team and be requested to have present the director of the hospital or his representative and the directors of the medical services being surveyed, in addition to all ancillary services (nursing, social service, physical and occupational therapy). The length of time necessary for the survey depends to a great extent upon the size of the hospital and its problems. The minimum time necessary in the average large hospital is one full day if there is to be observation of patient care, physical setup, and ancillary services (operating room, laboratories, x-ray, blood bank, physical and occupational therapy) and a review made of staff qualifications, charts and records, and policies and procedures. If the service being reviewed has an outpatient department, at least another half day is required to review this activity.

Following the survey, one member of the consulting team is assigned responsibility for writing the report and for drafting the letter of recommendations to be sent to the hospital. The report and the letter are written with the team members who have made the survey and agreed upon recommendations are drawn up. The final letter of recommendations is sent to the hospital administrator, the medical directors of the services concerned, the director of nursing service, and the director of the social service department. If the hospital consultation is part of an ongoing program and the survey represents a periodic visit where no major deficiencies in patient care are noted, the team itself usually assumes full responsibility for the recommendations. If the institution is new to the program, or if special problems have arisen since the last survey, the team may then ask its advisory committee for assistance. In general, major policies and decisions are brought to the advisory committee for guidance and assistance.

Usually a period of several months elapses between the sending of the letter of recommendations and the postsurvey conference at the hospital. The reason is to enable the key staff members of the hospital to review the recommendations and to get together among themselves to discuss them. The conference is held at the hospital by the survey team with the key hospital personnel, although frequently medical residents and supervis-

ing and head nurses are invited by their directors. The conference consists of a review of the finding and recommendations with a considerable amount of discussion. The hospital staff is again informed that the recommendations are not criticisms of the hospital policies and practices, but an attempt to assist them with improvement in patient care. The conference usually lasts a half day. In many of the better institutions, a good proportion of the recommendations have already been carried out by the time the conference is held, and the conference time is spent in discussing those recommendations in which the hospital staffs may need the assistance and further interpretation by the team.

Follow-up activities depend to a great extent on the needs of the individual institution. The following partial list of cooperative efforts is self-descriptive: assisting the director of nursing service in replanning the nursing service; assisting in securing additional training for medical and nursing personnel; assisting the administrator of the hospital in reorganization of the social service department; reviewing policies and manuals developed by the hospital staff; sending materials prepared by the health department to the hospital staff (standards, manuals, description of procedures); suggesting the names of institutions with desirable features in the same geographical area which the hospital staff might visit; reviewing blueprints; discussing revamping of the medical intern and resident training program; presentation of materials and discussions at the hospital's medical and nursing staff conferences; and assistance with the organization of the outpatient service with special reference to coordination of inpatient and follow-up care.

Promotion of Better Community Planning—Over and above the use of the hospital consultation program for the improvement of the care of the patient in the individual hospital is another equally important function of the program, namely, better community planning. A few examples will illustrate this function. Surveys of maternity and newborn services in New York City revealed substandard care of premature infants in many hospitals. From these surveys the concept of premature centers evolved and steps were taken to assist in the development of such centers. Preliminary surveys indicate that there is more than an adequate number of hospital beds for children with orthopedic and cardiac handicaps. This oversupply is probably related to postwar expansion of services and to the decrease in such orthopedic defects as osteomyelitis, rickets, and tuberculosis of bone and joint on the one hand, and to some decrease in rheumatic fever and rheumatic heart disease due to the use of antibiotics and sulfa drugs on the other. Thus, emphasis in the orthopedic and cardiac programs should be in the consolidation of existing services many of which are considerably deficient in essential details. Preliminary surveys also indicate a dearth of complete services for the total rehabilitation of children with speech and hearing impairment, cleft palate, and epilepsy. A hospital consultation program should be able to stimulate the development of new services to fill currently unmet needs and to discourage the overprovision of services the need for which are already met quantitatively in the community. In this way the available resources and funds can best be used for the benefit of a larger number of patients in the community.

Consideration of Legal Authority and Financial Assistance—Frequently, several questions relating to this have been raised with us: "Do you need legal authority in order to develop a hospital consultation program?" "Does legal authority seriously interfere with an effective educational hospital consultation program?" "Is payment for hos-

pital care necessary for a hospital consultation program?" The authors have participated to date in five types of activities in the hospital consultation field in which the questions of legal authority and payment for care have varied. In three programs there has been payment for care, but no legal authority for enforcing standards. In the fourth program there was complete legal authority, and in the fifth program partial legal authority for enforcing standards; neither of these last two programs paid for hospital care.

Based upon these five types of experiences, it is our opinion that in the case of institutions of moderate-to-high caliber with a good staff interested in the improvement of patient care, the institution welcomes the consulting team and productive surveys and conferences are usually the rule without the need for legal authority. In the case of institutions of low caliber legal authority is necessary. This type of hospital has, with a few exceptions, taken the position that they will institute only those changes required by law. In essence, if patient care were rendered only by institutions truly performing a community service, legal authority for a hospital consultation program probably would not be necessary.

In regard to the question "Does the fact that there are legally required standards for hospital care interefere with the development of a truly effective educational hospital consultation program?", the answer will depend to a great extent upon the attitude and efficiency of members of the consultation team as was discussed earlier. Standards required by law are usually minimum standards and a small percentage of hospitals in a community will by themselves provide care of a caliber higher than that required by law. In a considerable percentage of community hospitals, the staff will be interested in improving patient care beyond the level of minimum legal requirements. If legal requirements are administered with reason and understanding, the participating institutions can usually be encouraged to improve their services by an effective educational program, both at the time of hospital surveys and conferences, and by other types of educational activities in the community.

Payment is certainly a factor in the success or failure of a hospital consultation program with several types of qualifying limitations. Ideally, payment should be on a cost basis. The "paperwork" in the payment program should be kept as simple as possible and bills should be paid promptly. If these conditions can be met, there is no question that the payment factor will make it easier for the program to succeed more quickly since surveys and recommendations can carry with them the responsibility to administer the payment for patient care. This is particularly true in the New York City program for prematurely born infants, where there was a dearth of good services at the beginning of the program. On the other hand, a hospital consultation program can succeed without payment (as in the case of the New York City maternity and newborn program), but it will undoubtedly take longer to do since it will depend more upon the integrity of the hospital staff in its desire to improve patient care. In addition to financial assistance offered to institutions under a payment program, hospitals are eager to meet standards and participate because once they are on the approved list, physicians, social and health agencies refer cases to them resulting in enlargement and improvement of the respective medical services. If a public health program includes payment for patient care, concomitant steps should be taken to evaluate and periodically to re-evaluate the quality of this care being purchased and to assume financial responsibility only if it meets the estab-

lished standards. If these concomitant steps are not taken, it is likely that public funds may be wasted and patients may receive substandard care.

Summary

Hospital consultation has played a relatively minor role in many public health programs throughout the country. It is suggested that expansion of hospital consultation services will assist hospitals in improvement in patient care and will assist official public health agencies in fulfilling their responsibilities in the areas of standard setting and standard raising, and in the optimum utilization of tax funds in the purchase of hospital care for patients.

REFERENCE

1. Bureau for Handicapped Children, New York City Department of Health. Standards Recommended for the Hospital Care of Children with Orthopedic Handicaps, 1952, 11 pp.

Another Regional Education Compact

Congress has passed and the President has signed a bill (S. 3726) which authorizes the six New England states to establish the New England Board of Higher Education. The purpose of such a board is stated to be "to provide greater educational opportunities and services through the establishment and maintenance of a coordinated educational program . . . with the aim of furthering higher education in the fields of medicine, dentistry, veterinary medicine, public health, and in professional, technical, scientific, and other literary fields." The compact becomes effective for those states executing it as soon as two or more of the six states have accepted it.

The plan is that the compacting states will cooperate in providing higher educational facilities for their citizens without the necessity for each state to set up its own schools. For example, only Connecticut and Massachusetts presently have schools of medicine and of public health and in neither state are they state schools.

Earlier examples of this type of regional cooperation in education are to be found in the Southern Regional Education Board initiated in 1948 by 14 states without federal legislative action and the Western Interstate Commission for Higher Education created by authorization of Congress in 1953 and applying to 11 states, Alaska, and Hawaii. (See A.J.P.H. 43, 6:773 (June), 1953).